Editorials

Change—Threat or Opportunity

STUDS TERKEL, writer and reporter, said recently that change is inevitable but often resisted or even opposed. Although sharing change can be a bond and relishing change can be invigorating, physicians especially resist change forced by others or required by regulations.

Physicians face accelerating pressures to change: challenging scientific discoveries, new techniques, administrative restrictions, patients' demands, new forms of competition, and more rigorous quality assurance. Fox, Mazmanian, and Putnam, in a study of 340 physicians, found that we meet change in several ways.[1] Some accommodate passively and tend to be angry and resentful as they do so. Most make incremental moves. Others find entirely new directions to explore. They transform.

What causes physicians to change? A few change because they want to excel. Many become aware of innovations and react to them gradually. Some seek new solutions stimulated by patients' difficult problems. Regardless of motivation, making modifications requires repetition of new data or circumstances. Learning and changing are not first-pass phenomena. Finally, a variety of sources of information are necessary—experts, colleagues, literature, seminars, courses, and rounds.

One element in a successful approach to change is involvement. Whether change is sparked by scientific advances or imposed by public policy, physicians who adapt are the ones who participate. They ask questions. They request consultations. They vote. They run for office. They study. They write letters to professional organizations, to editors, to political leaders and other policymakers. They make themselves heard. They convert negatives to positives, so problems become challenges. They take risks. They recognize that others are undergoing change during these troubled economic times. To borrow from Arnold Toynbee, they regard medicine as a "movement and not a condition; a voyage and not a harbor."

Physicians who cope well do so by observing, thinking, and acting. They view change as opportunity.

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REFERENCE

1. Fox RD, Mazmanian PE, Putnam RW (Eds): Changing and Learning in the Lives of Physicians. New York, Praeger, 1989

Retinal Vasculitis

DISEASES OF THE RETINAL VASCULATURE are among the most serious problems in ophthalmology. They form a heterogeneous group of disorders that includes such diverse afflictions as the chronic retinal ischemia associated with diabetic microvasculopathy and the sudden, devastating visual loss of a central retinal artery occlusion. In this issue, Rosenbaum, Robertson, and Watzke present an overview of one important, but poorly understood, category of vascular disease: retinal vasculitis.[1]

Retinal vasculitis should not be considered a single disease entity. It appears to be a nonspecific immunologic reaction of retinal arterioles or venules to various antigenic stimuli and is a finding in many different systemic and local disease states. In some patients, vasculitis results in no visual disturbance. The disorder can, however, lead to serious, sight-threatening complications, including vascular occlusion with infarction of the retina, or vascular leakage with retinal edema. Late sequelae may include retinal neovascularization leading to vitreous hemorrhage or tractional retinal detachment.

Because retinal vasculitis can be a manifestation of systemic disease, it is often evaluated and managed best by an ophthalmologist and internist working as a team, drawing on each other's special skills and experience. An organized approach to retinal vasculitis is clearly needed to ensure the best patient care.

Included in this approach should be the appropriate use of terms to facilitate communication, yet even the designation "vasculitis" has been a source of confusion. Strictly speaking, the adjectival ending "-itis" indicates inflammation, but in practical terms, many vascular disorders have been called vasculitis by ophthalmologists, whether or not they are characterized histopathologically by the presence of inflammatory cells in vessel walls. Confusion arises because the signs and complications of retinal vasculitis may be mimicked by noninflammatory disorders. Vascular sclerosis, for example, can occasionally be confused with inflammatory sheathing of vessels. Furthermore, vascular occlusion by inflammation, thrombus formation, and embolization can all result in a similar clinical picture. Although ophthalmologists have the unique opportunity to view retinal vessels through transparent media, the tissues are not available for routine biopsy and clinicopathologic correlation.

Unfortunately, various vascular disorders that are not primarily inflammatory have been called retinal vasculitis. "Benign retinal vasculitis," for example, is a unilateral condition of young adults characterized by optic nerve head swelling that can mimic central retinal vein occlusion.[2] Although an inflammatory cause is hypothesized by some,[3] abnormal clotting and fibrinolytic mechanisms are thought to be the underlying cause by others.[2,4] Use of the term "vasculitis" for the ocular disease associated with systemic lupus erythematosus (SLE) is particularly confusing. It is usually an occlusive microvascular disease that can lead to cotton-wool spot formation (areas of nerve-fiber layer swelling caused by ischemia) and occasionally to retinal hemorrhage. A more severe vaso-occlusive disease of larger vessels can also occur. Histopathologic studies show that vessels are occluded with amorphous hyaline material without evidence of inflammatory cells in vessel walls.[5] True retinal vasculitis is only rarely a feature of the disease. "Severe retinal vaso-occlusive disease" is probably a preferable name for this disorder.[6]

There are no well-established criteria for the clinical diagnosis of retinal vasculitis. Among the more useful definitions, however, is one proposed by Graham and co-workers.[7] They define retinal vasculitis as the vascular leakage and staining of vessel walls on fluorescein angiography, with or without the clinical appearance of fluffy, white perivascular infiltrates in an eye with evidence of inflammatory cells in the vitreous body or aqueous humor. When called on to examine a patient with "retinal vasculitis," it is appropriate for internists to ask the referring ophthalmologist if, in fact, the vascular disease appears to be inflammatory by these criteria. If